ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Aging and Adult Services

FAMILY CAREGIVER REIMBURSEMENT PROGRAM PACKET

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ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Aging and Adult Services

ARIZONA FAMILY CAREGIVER REIMBURSEMENT PROGRAM APPLICATION

Starting January 1, 2020, family caregivers can be reimbursed **50% of costs for home modifications and assistive care technology up to $1,000** for each qualifying family member. The qualified family member(s) must be 18 years or older and requires help with one (1) or more activities of daily living. This program is first come first served.

IMPORTANT INFORMATION

- Applications will be reviewed on a first-come, first serve basis upon submission of application due to limited funding.
- Family caregivers are not eligible to apply for the grant again after receiving $1,000 for each qualifying family member.
- For reimbursement over $600 a 1099 tax form will be issued to the applicant and is considered taxable income.

You will need all required documents (detailed below) at the time of submitting this application.

Return this application to the **Arizona Caregiver Coalition**
P. O. Box 21623 Phoenix, Arizona 85036 or email to CRL@azcaregiver.org or fax 888-288-6293.

Date of application: _____

Total amount requested for reimbursement (50% of qualifying expenses, up to $1,000): $ _____

Describe the project or equipment purchased:

Referral Source:
☐ Family/Friend ☐ Physician ☐ Hospital ☐ Agency ☐ Senior Center ☐ Other _____

FAMILY CAREGIVER INFORMATION *(individual completing the application)*

Legal Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Phone (home, work, cell): _____

Email: _____

Arizona Resident: ☐ Yes ☐ No

Gender: ☐ Male ☐ Female ☐ Declined to state

Race: ☐ Asian ☐ Black/African American ☐ Native Hawaiian or Pacific Islander
☐ American Indian or Alaskan Native ☐ White ☐ Other ☐ Declined to state

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to state

Preferred method of communication: ☐ Email ☐ Mail

Relationship to the family member:
☐ Spouse ☐ Child ☐ Grandchild ☐ Stepchild ☐ Parent ☐ Stepparent ☐ Grandparent ☐ Sibling
☐ Uncle or Aunt whether whole or half blood or by adoption ☐ Domestic Partner ☐ In-law

Length of time providing care for the family member:
☐ Less than 1 year ☐ 1-2 years ☐ 3-5 years ☐ 6-10 years ☐ 11 or more years

How much did this home modification and/or assistive care technology help to keep your family member living at home?
☐ Not at all ☐ Some ☐ A great deal ☐ Unknown ☐ Refuse to answer

See page 4 for EOE/ADA disclosures

*** Qualified Family Member is the individual receiving care.**

QUALIFIED FAMILY MEMBER (1)

Legal Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Phone (home, work, cell): _____

Email Address: _____

Arizona Resident: ☐ Yes ☐ No

Gender: ☐ Male ☐ Female ☐ Declined to state

Veteran: ☐ Yes ☐ No ☐ Declined to state

Race: ☐ Asian ☐ Black/African American ☐ Native Hawaiian or Pacific Islander
☐ American Indian or Alaskan Native ☐ White ☐ Other ☐ Declined to state

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to state

Amount requested for family member (1) reimbursement (50% of qualifying expenses, up to $1,000):

$ _____

QUALIFIED FAMILY MEMBER (2)

Legal Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Phone (home, work, cell): _____

Email Address: _____

Arizona Resident: ☐ Yes ☐ No

Gender: ☐ Male ☐ Female ☐ Declined to state

Veteran: ☐ Yes ☐ No ☐ Declined to state

Race: ☐ Asian ☐ Black/African American ☐ Native Hawaiian or Pacific Islander
☐ American Indian or Alaskan Native ☐ White ☐ Other ☐ Declined to state

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to state

Amount requested for family member (2) reimbursement (50% of qualifying expenses, up to $1,000):

$ _____

QUALIFYING EXPENSES

- Improving or altering the family caregiver **or** the qualifying family member's owned or rented primary residence
- Purchasing/leasing equipment or assistive care technology for the qualified family member to enable/assist/carry out one or more activities of daily living (toileting, bathing, dressing, grooming, eating, mobility, or transferring)

Examples of qualifying expenses **are not limited to this** list and include:

Home Modification Costs

- Widening of doorways
- Ramps/low inclined walkways
- Adaptive switches
- One-bathroom environment
  - (roll-in/curb-less) accessible shower
  - roll-under sink
  - high rise toilet with handrails
  - handrails and grab bars in accessible shower

Assistive Care Technology

- Hearing aids
- Eating: adaptive utensils, dentures
- Transferring: Hoyer lift, gait belt
- Toileting; bedside commode
- Bathing: shower chair/bench, handheld shower head
- Vehicle wheelchair lift
- Dressing assistance; buttoning aid hook, long reach comfort wipe
- Mobility: Bed handles, wheelchairs, scooters, walkers, canes
- Communication devices; voice recognition programs, screen readers, screen enlargement applications
- Monitoring systems: medical alert devices
- Computer software and hardware: voice recognition programs, screen readers, and screen enlargement applications

EXPENSES *NOT* ALLOWABLE

- Regular food, clothing or transportation expenses, gifts provided to the qualified family member
- Ordinary household maintenance or repair that is not directly related to and necessary for the care of the qualified family member
- Any amount that is paid for or reimbursed by the insurance or by the federal government or state of Arizona
- Covered expenses from the qualified family member's insurance policy

The following statements include the documents required to apply for the program. Please read the following statements and initial each blank line below.

_____ I agree that the qualified family member and I must be 18 years or older. I will provide a copy of **one (1)** of the following for **both** of us:

- Arizona driver's license
- ID card (with birthdate)
- Birth certificate

_____ I agree that the qualified family member and I must be residents of Arizona.
Note: For home modifications and if renting, any construction or alteration of the residence must be authorized by the owner.
I will provide a copy of **one (1)** of the following for **both** of us:

- Arizona driver's license
- Utility bill
- Arizona Voter Registration Card

_____ I agree that I will need to provide proof that the qualified family member(s) requires assistance with one or more activities of daily living (ADLs).
I will provide a signed copy of the Medical Need Verification form (provided) and signed by a Physician, Nurse Practitioner (NP) or Physician's Assistant (PA), case manager or care coordinator for each qualifying family member.

_____ I agree that I will provide proof of my gross income **and** the qualified family members gross income in the taxable year.

_____ I will provide a copy of **one (1) or more of the following for each person:**

- Income taxes
- Social Security award
- Pay stub
- Veteran Award Letter
- Any public benefit award letter (TANF, SNAP, etc.)

Note: The family caregiver and each qualifying family member's income in the taxable year may not exceed:
$75,000 for a single person or a married person filing separately
(caregiver + qualified family member = total gross income)
or
$150,000 for a married couple filing a joint return
(caregiver + spouse + qualified family member = total gross income)

_____ I understand that I am required to complete a W-9 form (provided). Please fill out completely per the W-9 Instruction Sheet.
If approved and the amount requested for reimbursement is $600 or more, the reimbursement is then taxable. Arizona Department of Economic Security (DES) is required to provide a 1099- Misc tax form because it is a type of payment and I will need to declare the reimbursement amount as income when filing my taxes.

_____ I understand that if approved for the program, I will not be eligible to apply for the Arizona Family Caregiver Reimbursement Program after receiving $1,000.00 for each qualifying family member.

_____ I understand that I will provide a copy of receipts for qualified expenses. A statement is acceptable if an unlicensed individual completed the home modification and must include the individual's name, type of work performed and completed, contact information and date the project was completed. All receipts/statements must show a paid portion of the total invoice and date of payment.

_____ I understand that I will complete and return the Zarit Burden Interview Questions Form with the application packet. I will also be contacted for a follow-up survey to determine whether the home modifications or purchasing/leasing of assistive care technology delayed or prevented the qualified family member from entering a long-term care facility or assisted living facility in the calendar year of the application.

My signature on this form signifies that all information provided on this form is truthful and accurate. I further acknowledge that completion of this application does not guarantee that I will be eligible for the Arizona Family Caregiver Reimbursement Program.

Print Name: _____

Signature: _____ Date: _____

Please return this application by email to CRL@azcaregiver.org, fax 888-288-6293 or mail to:

Arizona Caregiver Coalition
P. O. Box 21623
Phoenix, AZ 85036

For questions contact a Caregiver Resource Specialist at (888) 737-7494.

AAA-1346A FORFF (5-21)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Aging and Adult Services

MEDICAL NEED VERIFICATION

Dear Healthcare or Social Work Professional,

Your patient's family caregiver is applying for the Arizona Family Caregiver Reimbursement Program (FCRP) through the Arizona Department of Economic Security, Division of Aging and Adult Services (DAAS). The FCRP is designed to reimburse family caregivers 50% of purchases up to $1,000 (per qualified family member). Qualified expenses include costs for home modifications or assistive care technology to keep the patient mobile, safe or independent.

DAAS requires a Medical Need Verification Form to be completed and signed by the Primary Care Provider (PCP), Nurse Practitioner (NP), Physician's Assistant (PA), a case manager, or care coordinator to verify the patient requires assistance with one or more activities of daily living (ADLs).

For questions, contact the Arizona Caregiver Coalition at (888) 737-7494.

Patient Name: _____ Date of Birth: _____

Family Caregiver Name: _____ Phone No.: _____

Mark all assistance with ADL's that apply:

☐ Toileting ☐ Bathing ☐ Dressing ☐ Walking ☐ Eating ☐ Transferring

TO BE COMPLETED BY HEALTHCARE OR SOCIAL WORK PROFESSIONAL

Your timely response is requested, the patient will be denied approval per the requirements for the Arizona Family Caregiver Reimbursement Program. Your signature certifies that your patient requires assistance with the selected ADLs.

Physician: _____

Provider Address: _____

Signature: _____ Date: _____

Nurse Practitioner (NP) or Physician's Assistant (PA): _____

Provider Address: _____

Signature: _____ Date: _____

Case Manager or Care Coordinator: _____

Provider Address: _____

Signature: _____ Date: _____

Please sign and return this document to the family caregiver contact noted below OR fax directly to the Arizona Caregiver Coalition at 888-288-6293.

Patient Name: _____ Email: _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____ Phone: _____

RETURN COMPLETED FORM TO

Family caregivers may return the form with the application packet via email to CRL@AZcaregiver.org, fax 888-288-6293, or mail to Arizona Caregiver Coalition P.O. Box 21623 Phoenix, AZ 85036.

DAAS
AFCRP

ARIZONA
DEPARTMENT OF ADMINISTRATION
GENERAL ACCOUNTING

State of Arizona Substitute W-9: Request for Taxpayer Identification Number and Certification

Submit completed form to the State of Arizona Agency with whom you are doing business with for review and authorization.

1 Type of Request (Must select at least ONE)

(•) New Request ( ) New Location (Additional Address ID) ( ) Change - Select the type(s) of change from the following: [ ] Tax ID [ ] Legal Name [ ] Entity Type [ ] Minority Business Indicator [ ] Main Address [ ] Remittance Address [ ] Contact Information

2 Taxpayer Identification Number (TIN) (Provide ONE Only)

TIN [ ][ ] - [ ][ ][ ][ ][ ][ ][ ] **OR** SSN [ ][ ][ ] - [ ][ ] - [ ][ ][ ][ ]

3 Entity Name (As it appears on IRS EIN records, IRS Letter CP575, IRS Letter 147C or Social Security Administration Records, Social Security Card. If Individual, Sole Proprietor, Single Member LLC, enter First, Middle, Last Name.)

Legal Name

DBA Name

4 Entity Type (Must select ONE of the following)

(•) Individual/Sole Proprietor or Single-Member LLC	( ) The US or any of its political subdivisions or instrumentalities
( ) Corporation	( ) A state, a possession of the US, or any of their political subdivisions or instrumentalities
( ) Partnership	( ) Other: Tax Reportable Entity
( ) Limited Liability Company (LLC) including Corporations & Partnerships	( ) Other: Tax Exempt Entity

Description

5 Minority Business Indicator (Must select ONE of the following)

( ) Small Business	( ) Small, Woman Owned Business- Hispanic	( ) Minority Owned Business- African American
( ) Small Business- African American	( ) Small, Woman Owned Business- Native American	( ) Minority Owned Business- Asian
( ) Small Business- Asian	( ) Small, Woman Owned Business- Other Minority	( ) Minority Owned Business- Hispanic
( ) Small Business - Hispanic	( ) Woman Owned Business	( ) Minority Owned Business- Native American
( ) Small Business- Native American	( ) Woman Owned Business- African American	( ) Minority Owned Business- Other Minority
( ) Small Business- Other Minority	( ) Woman Owned Business- Asian	( ) Non-Profit, IRC §501(c)
( ) Small, Woman Owned Business	( ) Woman Owned Business- Hispanic	( ) Non-Small, Non-Minority or Non-Woman Owned Business
( ) Small, Woman Owned Business- African American	( ) Woman Owned Business- Native American	(•) Individual, Non-Business
( ) Small, Woman Owned Business- Asian	( ) Woman Owned Business- Other Minority	

6 Veteran Owned Business [ ] YES [ ] NO

7 Entity Address

Main Address (Where tax information and general correspondence is to be mailed)

Address Line 1
Address Line 2
City | State | Zip code

Remittance Address (Where payment is to be mailed) [ ] Same as Main

Address Line 1
Address Line 2
City | State | Zip code

8 Vendor Contact Information

Name			Title
Phone	Ext.	Fax	Email

9 Exemption from Backup Withholding and FATCA Reporting: Complete this section if it is applicable to you. See instructions for more details

Exemption Code for Backup Withholding | Exemption Code for FATCA Reporting

0 Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct Taxpayer Identification Number, and
2. I am not subject to Backup Withholding because: (a) I am exempt from Backup Withholding, or (b) I have not been notified by the IRS that I am subject to Backup Withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to Backup Withholding, and
3. I am a US citizen or other US person, and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Certification instructions: You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN.

Signature	**Print Name**	**Date**

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Aging and Adult Services

State of Arizona Substitute W-9: Request for Taxpayer Identification Number And Certification

INSTRUCTIONS ON HOW TO COMPLETE THE SUBSTITUTE W-9 FORM

The Arizona Substitute W-9 must be completed by the family caregiver.

Section 1	Select “New Request”.
Section 2	Enter family caregiver’s Social Security Number (SSN). **Please print legibly.**
Section 3	Enter family caregiver’s name on the “Legal Name” line. This should be exactly as it appears on your tax forms - it is how the IRS knows you.
Section 4	Entity Type - This should be “Individual/Sole Proprietor or Single-Member LLC”.
Section 5	Minority Business Indicator - This should be “Individual, Non-Business”.
Section 6	Veteran Owned Business. If Caregiver is a Veteran - check **YES**, otherwise **NO**.
Section 7	Entity Address: • “Main Address” is the address where the family caregiver’s IRS tax information is mailed. • “Remittance Address” only fill this in if it is different than the “Main Address.”
Section 8	Vendor Contact Information – family caregiver will fill this in with family caregiver’s Name *(must match Legal Name is Section 3)*, Phone, and Email Address.
Section 9	Leave blank. This area is not to be filled in.
Section 10	Family caregiver will sign the form, print caregiver name, and fill in the date.

The W-9 Form must be scanned/emailed to CRL@azcaregiver.org or faxed back to 888-288-6293.
Please do not take a picture and send this form in, it will not be processed.

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Aging and Adult Services

Arizona Family Caregiver Reimbursement Program
FREQUENTLY ASKED QUESTIONS (FAQ)

General Information

Does this program provide financial assistance to provide care for my family member?

No, the program reimburses family caregivers who pay upfront for the cost of home modifications or purchasing/leasing assistive care technology for their qualified family member.

Who is considered a family caregiver?

Any immediate family member who is currently caring for an older adult, an individual living with a chronic illness or disease, and an individual living with a disability. Family caregivers can be a spouse, domestic partner, child, parent, in-law, stepchild, grandchild, grandparent, siblings or other relatives' caregivers including aunts and uncles.

How do I know if I qualify for the program?

The family caregiver must provide a copy of:

- **Receipt(s):**
  The family caregiver pays upfront (on or after January 1, 2020) for the cost of home modifications or purchasing/leasing assistive care technology. Receipts may be saved up starting January 1, 2020 and submitted with one application.
    a. A statement is acceptable by an unlicensed individual that completed the home modification. The statement must include the individual's name, type of work performed and completed, contact information, and date the project was completed.
- **Income:** Provide proof of income for family caregiver **AND** qualifying family member(s):
    a. Income taxes
    b. Social Security Income (SSI) award
    c. Pay stubs
    d. Veteran Award Letter
    e. Any public benefit award letter (TANF, SNAP, etc.)
        - Total **combined** income for family caregiver and qualified family member's income **must not exceed**:
          $75,000/year in total gross income
          (Caregiver + Qualified Family Member = total gross income)
        - or
        - As a couple, earn less than $150,000/year in total gross income
          ((caregiver + spouse) + qualified family member = total gross income)).

- **Age:** Be 18 years or older. Provide any one of the following for family caregiver **AND** qualifying family member:
    a. Arizona driver's license
    b. ID card (with date of birth)
    c. Birth certificate
- **Arizona Residency:** Family caregiver and qualified family member must be Arizona residents, provide one of the following for each person:
    a. Arizona driver's license or identification card
    b. Arizona Voter Registration card
    c. Current utility bill
- **Completed W-9:**
  Included with the application and required for a check to be issued to the family caregiver. Please refer to the W-9 Instructions Page. W-9 Forms that are incorrectly filled out will not be accepted and could potentially delay processing of the application.
- **Signed Medical Need Verification Form**
  The form must be signed by a Physician, Nurse Practitioner (NP), Physician's Assistant (PA), case manager, or care coordinator to validate assistance with one (1) or more activities of daily living requirement. The qualified family member must:
    a. **Require assistance with one (1) or more activities of daily living** (toileting, bathing, dressing, grooming, eating, mobility, or transferring).
    b. **Be 18 years or older.**

Is this program for older adults only?

No, family caregivers who care for an adult 18 years or older can apply for the program.

When does the program start?

January 1, 2020.

Program Qualifications

Does the qualified family member have to live in the caregivers' home to qualify?

No. The FCRP excludes individuals that reside in institutionalized settings.

There is a combined gross income requirement for the family caregiver and qualified family member. The qualified family member and I together make more than $75,000 per year in gross income, do I qualify?

Unfortunately, no.

There is a combined gross income requirement for the family caregiver and qualified family member. My spouse and I file our taxes together and combined with the qualified family member, we make more than $150,000 per year in gross income, do we qualify?

Unfortunately, no.

If I modified my home or purchased/leased assistive care technology for my family member in 2019 or earlier, do I qualify?

No, the modifications and purchases must be on or after January 1, 2020.

I'm caring for my child who requires my home to be modified and/or needs assistive care technology, do I qualify?

Yes, if the following criteria are met:

1) Your child is 18 years or older.
2) Your adult child requires assistance with one (1) or more activities of daily living (toileting, bathing, dressing, grooming, eating, mobility, or transferring). With the application, you will submit the Medical Need Verification Form (provided) that needs to be signed by a Physician, Nurse Practitioner (NP), Physician's Assistant (PA), case manager, or care coordinator.
3) You earn $75,000/year or less or as a couple, earn less than $150,000/year and provide proof of income with a copy of one of the following: income taxes, Social Security Income (SSI) award, pay stub, Veteran Award Letter or any public benefit award letter (TANF, SNAP, etc.)
4) You provide receipts for home modifications and/or assistive care technology.
5) You provide proof of your age **and** your qualified family members age with copies of your Arizona driver's license **or** ID card (with birthdate) **or** birth certificate.
6) You provide proof of Arizona residency with a copy of your Arizona driver's license, Arizona Voter Registration Card **or** utility bill.

If there are more than one person receiving care in my home, do they need to apply separately?

No, the option to include more than one qualified family member on the application is provided on the application. All required documents including residency and income must be included for each qualifying family member. NOTE: Each qualifying family must have a Medical Need Verification Form.

What is considered a home modification?

Improving or altering the family caregiver's primary residence involves making changes to the livable spaces accessible to your family member to be safe and independent

Examples include, but **not limited** to:

- Widening of doorways
- Ramps/low inclined walkways
- Stair lift
- Adaptive switches
- One-bathroom environment
    - (roll-in/curb-less) accessible shower
    - roll-under sink
    - high rise toilet with handrails
    - handrails and grab bars in accessible shower

What is considered assistive care technology?

Examples include, but **not limited** to:

- Hearing aids (may be for family caregiver to ease communication challenges)
- Eating: adaptive utensils, dentures
- Transferring: Hoyer lift, gait belt
- Toileting; bedside commode
- Bathing: shower chair/bench, handheld shower head
- Vehicle wheelchair lift
- Dressing assistance; buttoning aid hook, long reach comfort wipe
- Mobility: Bed handles, wheelchairs, scooters (batteries), walkers, canes
- Communication devices; voice recognition programs, screen readers, screen enlargement applications
- Monitoring systems: medical alert devices, in-home cameras, auto fall detection devices connected to cellphones/mobile phones, movement/call buttons, personal alarms – pressure alarms for w/c or beds
- Computer software and hardware: voice recognition programs, screen readers, and screen enlargement applications
- May include skin barrier creams, mattress liners, under pads, adult briefs, wipes, gloves, medication crushers/cutters, thermometers, blood pressure cuffs, etc.

When I apply for the program, can I submit receipts for home modifications AND assistive care technology for reimbursement?

Yes.

Application Process

If a family caregiver is receiving services, can they still apply for the program?

Yes, the program is to provide reimbursement for home modifications and purchasing/leasing assistive care technology.

How do I get an application to apply?

Contact the Arizona Caregiver Coalition's Caregiver Resource Line at (888) 737-7494, by email at CRL@azcaregiver.org or complete the online pre-screening at www.azcaregiver.org. A Caregiver Resource Specialist will email or mail the application packet to you. NOTE: June 21, 2024 is the last day to request an application by mail.

When is the deadline to apply?

June 30, 2024. ALL required documents must be postmarked, emailed, scanned or faxed on or before June 30, 2024. **No exceptions.** Note: June 21 is the last day to request an application by mail.

How do I submit my documents to the Arizona Caregiver Coalition?

There are three options to submit your application information.

1) Scan the requested documents and email to CRL@AZcaregiver.org
2) Fax to 888-288-6293
3) Mail to Arizona Caregiver Coalition P. O. Box 21623 Phoenix, AZ 85036

When will I hear back about my application?

Once your application has been received, you will receive a response within 90 days.

After I receive my reimbursement, is there anything else I should do?

You will be contacted within six (6) weeks of submitting your application as a follow up about the ability to keep the qualified family member at home.

Can I apply again if I've been denied?

Yes, although family caregivers are not eligible to apply for the grant again after receiving $1000 per qualifying family member.

Can I apply again if I received a reimbursement in 2020?

If you received $1000, no. If you received less than $1000, you may be eligible to receive the difference between the reimbursement and the $1000.

Do I need to submit a new application packet if I received a reimbursement less than $1000 in 2020?

No, if your and the qualified family member income did not change.

What is a 1099 form?

An Internal Revenue Service (IRS) form.

Why will I receive a 1099 form?

If the reimbursement amount is $600 or more, it is considered a form of payment. The Arizona Department of Economic Security (DES) is required to send a 1099 form to the family caregiver as the reimbursement is taxable income.

What do I have to do with the 1099 form?

Include the 1099 when filing your annual taxes.

More Questions

What if I have more questions?

Please contact a Caregiver Resource Specialist at (888) 737-7494 or email at CRL@AZcaregiver.org.

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Aging and Adult Services

Arizona Family Caregiver Reimbursement Program
ZARIT BURDEN INTERVIEW QUESTIONNAIRE INSTRUCTIONS

The family caregiver data collected from the Arizona Family Caregiver Reimbursement Program will enable the Department of Economic Security - Division of Aging and Adult Services (DES/DAAS) to accurately report program outcome, need, and family caregiver burden to the Arizona State Legislature.

Please take a moment to complete this form and return along with the application packet.

Follow up: You will be contacted by the Caregiver Resource Line by phone, mail or email to complete this form 6 months from the date of determination.

Instructions: The Zarit Burden Interview (ZBI) Questionnaire is an effective tool for many health care and social work organizations for accurately gauging caregiver burden. *The questions and answers may help you to find insight about your overall mental and physical health. It is okay to feel angry, frustrated, guilt, stress, sad, or any mixture of complicated emotions, there are caregiver support programs you may be able to access.*

Definition: Family caregiving burden is defined as the experience of physical, psychological, emotional, social, or financial problems due to caring responsibility for an ill family member. Caregiving burden has been shown to be associated with caregivers' depression and poor quality of life (QoL) as well as patients' poor outcomes including reduced QoL, hospitalization, and death.

1. Take a few minutes to reflect on the 12 questions on the From A: Zarit Interview Questionnaire (provided).
2. Complete the questionnaire by using the 0 to 5 scale:
   0 – Never, 1 – Rarely, 2 – Sometimes, 3 – Quite Frequently, 4 – Nearly Always.
3. Tally up each column and record on the Total for each column.
4. Score Index:
   0 – 12 little to no burden
   13 – 24 mild to moderate burden
   25 – 36 moderate to severe burden
   37 – 48 severe burden
5. You may include your name or you may choose to remain anonymous. *The questionnaire will not use your name or other identifying information during data compilation and reporting.*
6. Return completed form with the application packet.
7. You will receive a follow up call in 6 months to complete this form again.
8. Outcomes will be provided to the Arizona State Legislature.

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Aging and Adult Services

FORM A: ZARIT BURDEN INTERVIEW QUESTIONS

(To be completed by the caregiver)

Indicate how often you experience the feelings listed by checking the box that best corresponds to the frequency of these feelings.

	Never	Rarely	Sometimes	Quite Frequently	Nearly Always
1) Do you feel that because of the time you spend with your relative that you don't have enough time for yourself?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
2) Do you feel stressed between caring for your relative and trying to meet other responsibilities (work/family)?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
3) Do you feel angry when you are around the relative?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
4) Do you feel that your relative currently affects your relationship with family member or friends in a negative way?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
5) Do you feel strained when you are around your relative?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
6) Do you feel that your health has suffered because of your involvement with your relative?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
7) Do you feel that you don't have has much privacy as you would like because of your relative?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
8) Do you feel that your social life has suffered because you are caring for your relative?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
9) Do you feel that you have lost control of your life since your relative's illness?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
10) Do you feel uncertain about what to do about your relative?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
11) Do you feel you should be doing more for your relative?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
12) Do you feel you could do a better job in caring for your relative?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

Score Index:

0 – 12 little to no burden
13 – 24 mild to moderate burden
25 – 36 moderate to severe burden
37 – 48 severe burden

Total for each column: _____ _____ _____ _____ _____

Total Score: _____